Version 04.08.2016

FSW IN.0387.R03.01 (Still Pending CMS Approval) - Revisions for 07.01.2016 RATE INCREASES

1. Request Information

A. The **State** of **Indiana** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Family Supports Waiver

C. Waiver Number:IN.0387
Original Base Waiver Number: IN.0387.

D. Amendment Number:IN.0387.R03.01

E. Proposed Effective Date: (mm/dd/yy)

07/01/16

Approved Effective Date of Waiver being Amended: 04/01/15

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

An amendment is proposed effective 07.01.2016 to include information regarding provider rate increases. Pursuant to legislative mandate (Indiana House Enrolled Act 1001, effective July 1, 2015 - https://iga.in.gov/static-documents/5/3/8/6/53861fe8/HB1001.05.ENRH.pdf - section 137, page 169), a 2.5% provider rate increase, which may result in service changes for participants, is scheduled for the following:

Community Based Habilitation – Individual
Facility Based Habilitation – Individual

Respite

MAIN MODULE
• Item 3 Nature of Amendment – updated to include reference to legislated rate increases
• Item 6. Additional Requirements, I. Public Input – updated to reflect public input opportunities, inclusive of opportunities to address legislated rate increases

APPENDIX I
Appendix I-2-a – updated to address legislated rate increases

APPENDIX J
Appendix J-1 – Updated to reflect legislated rate increases
Appendix J-2 – updated to reflect legislated rate increases

Corrective Action Plan submitted 03.18.2016
During the approval process for the Family Support Waiver (FSW) Renewal, CMS advised the State that approval would be contingent upon the State submitting a corrective action plan within 120 days of approval of the FSW. The corrective action plan was to be included within Main Attachment 1 to document the steps the State will take to ensure compliance with EPSDT services as defined by 1905(r) of the Social Security Act.

For this amendment, CMS advised the State that a public comment period, update to the HCBS Final Rule transition plan, and tribal notice were not required.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)

	Component of the Approved Waiver	Subsection(s)
☑	Waiver Application	Main Attacheme
☐	Appendix A – Waiver Administration and Operation	
☐	Appendix B – Participant Access and Eligibility	
☐	Appendix C – Participant Services	
☐	Appendix D – Participant Centered Service Planning and Delivery	
☐	Appendix E – Participant Direction of Services	
☐	Appendix F – Participant Rights	
☐	Appendix G – Participant Safeguards	
☐	Appendix H	
☑	Appendix I – Financial Accountability	I-2-a
☑	Appendix J – Cost-Neutrality Demonstration	J-1; J-2-c; J-2-d;

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☑ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☑ **Other**

Specify:

As required by CMS, the State had to amend the FSW renewal waiver to incorporate a corrective action plan into Main Attachment #1 to outline steps the State will take to address services within the waiver that may be more appropriate under EPSDT.

Additionally, pursuant to legislative mandate (Indiana House Enrolled Act 1001, effective July 1, 2015 - https://iga.in.gov/static-documents/5/3/8/6/53861fe8/HB1001.05.ENRH.pdf - section 137, page 169) a2.5% provider rate increase is scheduled for the following, which may result in service changes for participants:

Community Habilitation – Individual
Facility Habilitation – Individual
Respite

1. Request Information (1 of 3)

A. The **State** of **Indiana** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Family Supports Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

- **5 years**

Original Base Waiver Number: IN.0387

Waiver Number:IN.0387.R03.01

Draft ID:IN.007.03.01

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 04/01/15
Approved Effective Date of Waiver being Amended: 04/01/15

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients**. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of

care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

Public notice was provided 30 days in advance of the submission of the waiver amendment. Electronic notice was provided via the Indiana Register and DDRS listserv with paper copies distributed to participants/families by Case Management Companies. Paper copies of the amendment were available to the general public upon request from BDDS field offices. Comments were accepted electronically and/or in hard copies mailed to respective electronic and USPS addresses.

SPECIFIC TO THE 2014 RENEWAL

Specific to the Renewal of the Family Supports Waiver, public input was obtained through monthly meetings with the DDRS Advisory Council, as well as work groups and committees upon which stakeholders, providers and advocates participated.

• FSSA's DDRS held Quarterly Provider Meetings presenting its goals and objectives, and opening the floor for questions and comments.

• Once the original drafts were posted on the DDRS listserv of 5078 recipients, DDRS proactively sought the assistance of a nationally recognized organization and two professional trade associations in promoting the opportunity and encouraging stakeholders to provide comments, suggestions and opinions on the separately posted FSW Transition Plan (Attachment #2: Home and Community-Based Settings Waiver Transition Plan of the Main Module in the FSW renewal application) and draft renewal application (IN.007.03.00). Public comment periods were announced and posted as October 31 – December 1, 2014, for the FSW Transition Plan and November 7 – December 7, 2014, for the renewal application, but both timeframes were extended for the benefit of Tribal Governments.

Public comments on both documents were received in person during various meetings with participants, families, providers, advocates and other interested parties as well as electronically, in hard copy via US Postal Mail, and via verbal and typed comments during a series of family focused webinars.

Public comments revealed a need for several changes and clarifications and resulted in modifications to three proposed waiver-funded service definitions within the draft waiver renewal as well as additions and enhancements to the FSW Transition Plan. For example, regarding proposed service definitions, public comment was largely in opposition to the proposed mutual exclusion of Prevocational services with the new Extended Services for all participants. Thus, an exception was created for current users of both Prevocational services and Supported Employment Follow-Along, the service being replaced by Extended Services. For the Transition Plan, it was suggested that a Transition Task force be created. Convening a Transition Taskforce was added as remedial strategy to the Transition Plan. Comments and suggestions submitted after the close of each comment period are reviewed and kept on file for consideration within future updates and amendments.

ONGOING AND SPECIFIC TO ALL AMENDMENTS AND RENEWALS

DDRS maintains an open door to discuss issues, concerns, ideas and suggestions with families, advocates, providers and other stakeholders.

DDRS obtains public input and collaborates with key stakeholders in the state through the following methods:

• DDRS' Executive Management Team accepts public input from nationally recognized organizations, professional trade associations, and leaders among the service providers, in addressing concerns and suggestions on behalf of the group and the participants each represents in regard to DDRS program policy and operations. This input is considered as policies are developed. With FSSA’s approval, policies and updates are posted to DDRS' Website.

DDRS hosts Quarterly Provider Meetings (available in person or via WebEx) for statewide service providers announcing any waiver-related policy releases or updates authorized by FSSA, and meets with individual providers as needed or requested. DDRS also meets with small groups of parents and providers and intermittently attends other organized meetings of advocacy groups.

• The monthly Advisory Council meeting (established within IC 12-9-4) consisting of the Director of DDRS and ten other participants with knowledge of or interest in the programs administered by the Division. All ten are appointed by the Secretary of the Indiana Family and Social Services Administration, the State Medicaid Agency, and represent a wide and diverse membership including providers, parents, self-advocates, the Department of Education, and other Bureaus within the Division; including First Steps, Vocational Rehabilitation, and the Bureau of Quality Improvement Services. The Council's mission is to recommend strategies and actions that will ensure DDRS empowers people with disabilities to be independent and self-sufficient.
• DDRS maintains an electronic helpline available 24 hours daily, serving as a source of answering general questions surrounding programs, policies and procedures and as a receptor of suggestions and ideas from any interested party.
• Public forums and Webinars are held as needed toward the dissemination of program or operational changes.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003).**Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

☐ **Replacing an approved waiver with this waiver.**

☐ **Combining waivers.**

- [ ] **Splitting one waiver into two waivers.**
- [ ] **Eliminating a service.**
- [ ] **Adding or decreasing an individual cost limit pertaining to eligibility.**
- [ ] **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- [ ] **Reducing the unduplicated count of participants (Factor C).**
- [ ] **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- [ ] **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- [x] **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

ADDENDUM/TRANSITION PLAN FOR LEGISLATED RATE INCREASES

In 2015 FSSA/DDRS was legislatively mandated through Indiana House Enrolled Act 1001, (effective July 1, 2015 - https://iga.in.gov/static-documents/5/3/8/6/53861fe8/HB1001.05.ENRH.pdf - section 137, page 169) to implement a 2.5% provider rate increase on July 1, 2015 and an additional 2.5% rate increase on July 1, 2016. The rate increases may result in service changes for participants.

The July 1, 2016 rate increase applies to the following services: Community Based Habilitation – Individual; Facility Based Habilitation – Individual; Respite

The rate increases will have no impact and result in no differences between services covered in the approved waiver and those covered in the amendment. The rate increase has no impact on the continuation of services covered in the current waiver and adds no specific limitation to the amount of any waiver service that may be utilized by a waiver participant.

The rate increase has no impact on which waiver participants served under the existing, approved waiver will be eligible to participate in the waiver program once amended. All participants will be notified of the legislated changes by their Case Manager and will be informed of the opportunity to request a Fair Hearing. As described in Appendix F-1, all State-issued decisions related to participant service plans contain an explanation of how to request a Fair Hearing.

****THIS IS NOT A TRANSITION PLAN****

FSW Corrective Action Plan

Background

Contingent upon the approval of the Family Supports (FS) Waiver, IN.0387.R03.00, and in compliance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines (Section 1905 (r) of the Social Security Act), the State agreed that within 120 days of approval of the FS renewal or by October 30, 2015, an action plan would be submitted to the Centers for Medicare and Medicaid Services (CMS) via an amendment to the FS Waiver. On January 29, 2016, CMS issued a formal Request for Additional Information requiring the State to incorporate changes within the Corrective Action Plan.

CMS advised the State that all youth between the ages of birth through age 20 receiving services within the FS Waiver may need to transition to the Indiana Medicaid State Plan for those services as appropriate. CMS advised the State that it must develop a plan with timelines on how to transition those services and/or youth to receive EPSDT services under the Indiana Medicaid State Plan rather than through the FS 1915(c) waiver. Under the guidance of CMCS bulletin re: Clarification of Medicaid Coverage of Services to Children with Autism dated 7/07/2014, CMS FAQ re: Medicaid and CHIP FAQs: Services to Address Autism, and the EPSDT-A Guide to States: Coverage in the Medicaid Benefit for Children and Adolescents, the State began to engage in conversations with CMS as the first step of the planning process.

Beginning in July, 2015, CMS and the State worked in conjunction to review and evaluate service definitions. In particular, CMS sent inquiries on the following services within the Community Integration and Habilitation Waiver and FS Waiver: occupational therapy; physical therapy; psychological therapy; speech/language therapy; behavioral support services; family and caregiver training; intensive behavioral intervention. CMS noted more information and ongoing technical assistance will be provided to assist the State with transitioning any of the above services.

On October 30, 2015 the State submitted a corrective action plan (CAP) in the portal. On

January 13, 2016, CMS issued a formal RAI requesting that the State incorporate changes within the CAP.

Additionally, for the services within the FSW that may be more appropriate under EPSDT services for youth through 21 years of age, the State will continue to monitor and report to CMS through an action plan separate from the FS waiver.

Timeline

The State offers the following timeline to CMS to work on complying with 1905(r) of the Social Security Act.

June 2015 - December 2015: The State will continue to work with technical assistance from CMS to identify services that may be redirected to the State Plan.

June 2015 - December 2015: With the assistance of CMS, the State will work with the subject matter experts within Indiana Medicaid to begin evaluating the State Plan and the service definitions that may need to be revised.

January 2016 - August 2016: Once services are fully identified, the State will work to determine fiscal impact for any services moving from the FS Waiver to the State Plan and create a stakeholder group to work on transparent communication plan for members and providers. The State will also continue to work with CMS for guidance and technical assistance. The State will draft a plan for provider enrollment with the non-traditional Medicaid providers who currently provided these services to the identified members under the HCBS waiver programs and will also work with the managed care entities to gain input on the processes and steps necessary for non-traditional provider enrollment. During this time, the State will also identify gaps of coverage, potential roadblocks to service delivery, and other similar issues. With CMS guidance and stakeholder input, the State will identify authorities that services may be included under, work with designing that benefit within that authority, develop a draft plan of the services, and identify systems changes that may be needed.

March 2016: OMPP will work with DDRS to evaluate definitions of Behavior Support Services and IBI to determine if these services need to be moved to the State Plan.

March 2016: OMPP will submit a SPA adding coverage of ABA therapy.

April 2016: OMPP will provide fiscal analysis of moving those services from FSW to the State Plan.

April 2016: DDRS will provide a fiscal impact by producing data around the current waiver service authorizations/costs for the impacted services that need to be transitioned to the State Plan (costs that would ultimately be removed from the waiver), along with information summarizing the number of individuals receiving these services.

June 2016: DDRS will coordinate with internal provider relations team to generate a list of waiver providers who are affected by the changes with EPSDT.

June 2016: DDRS will share with this list with OMPP in order to facilitate transition activities.

June 2016: DDRS will advise providers of the changes as the timeline for transition gets closer.

July 2016: DDRS and OMPP will issue guidance for providers on the enrollment plan, including instructions on where and how to enroll as a provider of state plan services.

August 2016: DDRS will provide enhanced training for case managers on EPSDT, including instructions on where and how to access those State Plan services to ensure that families are well informed.

August 2016: OMPP provider relations will work with DDRS provider relations on instructing providers on enrollment criteria.

August 2016: If deemed necessary, OMPP will submit any additional state plan amendments to CMS.

August 2016 - February 2017: With a draft plan completed, Indiana will determine, with stakeholder input, any revisions that may be needed. Once finalized, the State will begin the FS waiver amendment process and begin the rule promulgation process if needed for EPSDT

benefits for children with Autism Spectrum Disorder.

November/December 2016: DDRS will review and analyze the State's case management system to identify areas of impact and required system changes.

June 2017: Prepare FSW for tribal notice.

July 2017: Prepare FSW for public comment.

September 2017: End of public comment period. The State will begin compiling information from public comment, summarize feedback, and share with CMS.

October 2017: The State will submit FSW transition plan to CMS with plan on how to move any potential waiver members to state plan if applicable. Timeline for actual transition will be dependent on CMS approval of any State Plan changes.

January - April 2017: As identified, DDRS will formally request system edits to prevent affected services from being authorized for individuals under the age of 22.

April 2017: DDRS will ensure these system edits are implemented on or before effective date of the transition, which will likely require 30-60 days from approval date of the requested edit(s).

April 2017: DDRS will notify providers and families of the programmatic changes prior to implementation.

Upon CMS approval of the FSW and any potential state plan amendments, by early 2018, begin process to transition members/services as appropriate.

The above outlined transition plan is fluid and is dependent upon variables including: technical assistance provided, stakeholder feedback, provider enrollment, CMS approval, and financial sustainability.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

ADDENDUM
In 2015 FSSA/DDRS was legislatively mandated through Indiana House Enrolled Act 1001, (effective July 1, 2015 - https://iga.in.gov/static-documents/5/3/8/6/53861fe8/HB1001.05.ENRH.pdf - section 137, page 169) to implement a 2.5% provider rate increase on July 1, 2015 and an additional 2.5% rate increase on July 1, 2016. The rate increases may result in service changes for participants.

The July 1, 2016 rate increase applies to the following services: Community Based Habilitation – Individual; Facility Based Habilitation – Individual; Respite
The rate determination methodology outlined below continues to be the one used to establish rates for this waiver and for the services mandated for the increases.

FSSA retains final authority for rate setting and coverage criteria for all Medicaid services, including provider rates, the basis for any activities reimbursed through administrative funds, and state plan services provided to waiver participants.

The current Rate Determination Methods were carried forward from the prior renewal and will remain in effect for this waiver as described below. FSSA's Division of Disability and Rehabilitative Services (DDRS) initiated and implemented a standardized provider reimbursement rate methodology in CY 2009.

This methodology requires that providers be reimbursed for actual services delivered, that the rate for each waiver service is discreet and transparent, and that the rates treat all providers in a fair and equitable fashion. The standardized rate system was implemented in CY 2009.

EXTENDED SERVICES
For the new service Extended Services, the Extended Services rate in question was built upon the same cost centers and cost factors that have been utilized by DDRS since 2007 in the development of the existing rate for SEFA.

Explanations of the existing Rate Development Tasks & Timelines, and the Rate Methodology are as follows:

RATE DEVELOPMENT TASKS & TIMELINES

The provider reimbursement rate initiative involved three key tasks. These tasks were: reimbursement rate methodology review and evaluation; rate development and testing; and rate revision and implementation. A description of each task is as follows:

1. Reimbursement Rate Methodology Review and Evaluation: DDRS conducted a review of current provider expenditure and utilization data, reimbursement rate methodologies, assumptions and pricing incentives, budget forecasting and cost containment strategies, risk management and risk reserve practices. This review involved the examination of provider operating expense sheets, annual audited financial reports, and focused discussions with statewide provider organizations.

2. Rate Development and Testing: Initial provider reimbursement rates were published July 2007 and implemented over a twenty-four month period. These rates were based upon the fiscal and service utilization data, provider expenditure data, and program benchmarks based upon DDRS policy. This methodology / standard fee schedule identified critical cost factors and

relevant pricing benchmarks.

Rate testing was initiated in January 2008 and involved only providers in BDDS District 4. Rate testing was expanded statewide to all providers in January 2009.

3. Rate Revision and Implementation: Rate implementation began in January 2008 and became effective statewide in January 2009. Rate revisions were implemented based upon evaluation and testing findings.

DESCRIPTION OF RATE STRUCTURE

DDRS converted its provider reimbursement approach from a negotiated rate system to a standardized fee-for-service system for all of its Medicaid Home and Community-Based Services (HCBS) waiver program.

There were three major components to the DDRS Rate Initiative:

Rate Component #1 - Direct Care Staff Time as the Billable Unit: With the exception of adaptive equipment and transportation, all provider reimbursement for the Family Supports Waiver is based upon the amount of direct care staff time delivered to the participant by the provider. In order to meet the conditions for payment, the participant must be Medicaid eligible, enrolled, in attendance, and receive a HCBS service; and the direct care staff must be actively employed and present to provide the HCBS service. In addition, the service provided must be consistent with the participant's individualized support plan.

Rate Component #2 - Standardized Cost Centers: All provider reimbursement rates consist of four cost centers. These cost centers are:

• Direct care Staff Compensation: Two primary job classes were used from these compensation studies. Job classifications used for Personal Support Workers are staff who perform typical duties of a developmental disabilities attendant with a high school degree and no special training. Job classifications used for Habilitation Workers are staff who perform the duties of a developmental disabilities attendant with an Associate Arts degree or Certified Nursing Assistant, or special training.

• Employee Expenses: Employment related expenditures refer to the benefits package that is offered to all employees who are involved in the care and services provided to the person with disabilities and are divided into two groups.

Discretionary costs are those associated with benefits provided at the discretion of the employer and are not mandated by local, state, or federal governments. Non-discretionary costs are those related to employment expenditures that are mandated by local, State, and Federal governments and are not optional to the employer.
• Program Supervision and Indirect Expenses: Program Related Expenditures are those that were part of the operation of the setting in which residential habilitation occurred and related to the programs which occur within the setting, but are not directly tied to the direct care staff. They included program management and clinical staff costs as well as program operational expenses.
• General & Administrative Expenses: General and Administrative costs are those associated with operating the organization's business and administration and were not directly related to the clients or the programs that serve the clients.

Rate Component #3 - Other Factors: In addition, standardized cost centers were applied.

Historical expenditures were used by DDRS as the basis for transportation rates. The average cost per person was utilized and the transportation rate was applied only to people who were, at that time, receiving fewer than 35 hours per week of Residential Habilitation and Support each week under Indiana's comprehensive DD or Autism Waivers. (Note: While this uniform rate for Transportation services was developed using historical expenditures from other HCBS waivers, Transportation is available to all participants under the Family Supports Waiver and the rate was carried forward from the other HCBS waivers.)

Historically, for the September 1, 2012 Amendment, IN.0387.R02.02, historical expenditures were used by DDRS as the basis for Case Management rates, specifically through the review and analysis of the current cost of Case Management as an Administrative Service.

Participant Assistance and Care (PAC) rates were derived through review and analysis of its reimbursable activities in comparison to reimbursable activities associated with State Plan and what were at that time the comprehensive "DD Waiver" services offering components of

personal care and/or residential supports.

Additionally, the Medicaid agency now solicits public input on rate determination methods through collaboration with industry leaders in the collection and review of costs associated with the various service components. At any time, public comments may be received via the BQIS Helpline at BQISHelp@fssa.in.gov.

Information about payment rates is made available to waiver participants by their Case Manager. Current rates are continuously posted on the DDRS/BDDS website at:

http://www.in.gov/fssa/files/RatesChartDDRSWaivers.pdf

Prior to any rate changes, a bulletin of the rates is posted to IndianaMedicaid.com to advise providers of the rate changes. Once the changes occur, manuals are updated regularly to reflect the changed rates.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for waiver services flow directly from the providers to the Indiana Medicaid Management Information System and payments are made via Medicaid's contracted fiscal agent.

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Table 1
Family Supports Waiver

State of Indiana Family and Social Services Administration (FSSA)
Indiana Office of Medicaid Policy and Planning (OMPP)
Division of Disability and Rehabilitative Services (DDRS)

Third Renewal April 1, 2015 - March 31, 2020

Appendix J-1: Composite Overview and Demonstration of Cost Neutrality Formula

Level of Care:			**ICF/MR**				
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	**Factor D**	**Factor D'**	**Total: D+D'**	**Factor G**	**Factor G'**	**Total: G+G'**	**Difference (Column 7 less Column 4)**
1	$ 8,410.51	$ 5,247.32	$ 13,657.83	$ 76,142.02	$ 5,077.44	$ 81,219.46	$ 67,561.63
2	$ 8,797.00	$ 5,457.21	$ 14,254.21	$ 78,426.28	$ 5,280.54	$ 83,706.82	$ 69,452.61
3	$ 9,074.63	$ 5,675.50	$ 14,750.13	$ 80,779.07	$ 5,491.76	$ 86,270.83	$ 71,520.70
4	$ 9,298.80	$ 5,902.52	$ 15,201.32	$ 83,202.44	$ 5,711.43	$ 88,913.87	$ 73,712.55
5	$ 9,553.22	$ 6,138.62	$ 15,691.84	$ 85,698.51	$ 5,939.89	$ 91,638.40	$ 75,946.56

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care: ICF/IID		
Year 1	14171		14171	14171
Year 2	16942		16942	
Year 3	19713		19713	
Year 4	22484		22484	
Year 5	25258		25258	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Projected average length of stay has been updated for the third renewal to reflect recent experience and updated new entrant projections.

Continuing enrollment for the third renewal was developed based on actual current enrollment

as of September 2014, as well as projected new entrants through March 2015.

The State of Indiana is projecting approximately 3,500 new entrants per year for each year of the renewal. This is projected to result in net waiver slot growth of approximately 2,700 per year, after application of the historical lapse rate of 0.36% per month, or approximately 4.2% per year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Base Year data was updated to Waiver Year 4 of the second renewal: April 1, 2013 through March 31, 2014.

Factor D for Waiver Year 1 of the third renewal was projected from WY 4, second renewal data in the following manner:

- Unduplicated users were projected to increase proportionately with total slots

- Average units per user were projected to vary with average length of stay.

- Average cost per unit for WY 1 of the third renewal is illustrated at current (October 2014) reimbursement levels. Baseline data was adjusted to reflect rate increases effective January 1, 2014, in which rates increased by 2% for Residential Habilitation, Respite Services and Individual Facility and Community

habilitation. There was no rate increase for other services.

• From WY 1, average cost per unit was increased by 2% per year for WY 2 and subsequent years.

Adjustments to Baseline Data: WY 4 of the current renewal (April 1, 2013 through March 31, 2014) is the most recently completed waiver year for the FSW. However, the experience from this waiver year is unusual because of a large number of new entrants who were enrolled at the end of the waiver year. During the last month of WY 4, March 2014, there were 529 new entrants. This represents 6% of unique participants during WY 4 and approximately twice as many "last-month" enrollees as would have occurred had new entrants been spread evenly throughout the year.

Those who enroll during the last month of the waiver year sometimes are unable to arrange for all the services they desire until the next month, which in this case would also be the next waiver year, so the large number of late enrollees may have resulted in a low number of baseline users for most services. To address this concern, we have adjusted the number of unduplicated users for each service to reflect 3% higher participation than the baseline WY 4 experience. Case management utilization has been estimated at 100% of unduplicated participants (Inflating by 3% would have increased it beyond 100%).

Participant Assistance and Care participation has been estimated at 20% of total unduplicated enrollees. This service was introduced during WY 3 of the second renewal, and was still ramping up during WY 4.

Service modifications: The following services were modified for the third renewal, and the following assumptions were used in developing projections:

• Extended Services: This service is replacing the Supported Employment service offered under the second renewal. Extended services will be reimbursed based on a proposed initial hourly rate of $35.19. The monthly reimbursement tiers are being eliminated. The new service is projected to serve the same number of individuals as under the old structure, with no overall cost per

recipient impact.

• Adult Day Services: During the second renewal, this service could be billed in either quarter hour or half day units. Under the third renewal, the service will only be billable in quarter hour units. There is no projected impact on number of recipients or overall cost per recipient.

• Participant Assistance and Care: Under the third renewal, this service may be rendered and billed as a group service, with no more than four participants per group. The group rate will be the existing individual rate divided by the number of participants in the group. The group rate may allow for additional utilization, but at a lower rate. There is no projected impact on waiver expenditures.

• Music and Recreational Therapy: Under the third renewal, these services may be rendered and billed as group services, with no more than four participants per group. The group rate will be the existing individual rate divided by the number of participants in the group. The group rate may allow for additional utilization, but at a lower rate. There is no projected impact on waiver expenditures.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data was updated to Waiver Year 4 of the current renewal: April 1, 2013 through March 31, 2014.

Base year data was trended at 4.0% per year. The trend has been reduced from the 6% assumption used for the second renewal. This was done in order to reflect recent historical experience, and is consistent with a reduction in trend rates used for Indiana Medicaid budgeting and forecasting.

Indiana is planning to adjust its physician fee schedule to approximately 75% of Medicare, effective January 1, 2015. This is projected to increase reimbursement for affected services by 20% in aggregate. Affected services represent

approximately 10% of state plan service expenditures for this population, so in addition to annual trend, we have included a one-time adjustment of 2% to Factor D` for WY 1 of the renewal.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data was updated to Waiver Year 4 of the current renewal: April 1, 2013 through March 31, 2014.

Factor G was inflated forward at 3.0% per year. The trend has been reduced from 4% assumption used for the second renewal. This was done in order to reflect recent historical experience, and is consistent with a reduction in trend rates used for Indiana Medicaid budgeting and forecasting.

During WY 4, a 3% reduction to ICF/ID reimbursement was in effect. This reimbursement reduction was adjusted to 1% (approximately a 2% reimbursement increase), effective January 1, 2014. To reflect this, we have included a one-time 2% adjustment to Factor G for WY 1 of the renewal.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Base Year data was updated to Waiver Year 4 of the current renewal: April 1, 2013 through March 31, 2014.

Base year data was trended at 4.0% per year. The trend has been reduced from the 6% assumption used for the second renewal. This was done in order to reflect recent historical experience, and is consistent with a reduction in trend rates used for Indiana Medicaid

budgeting and forecasting. It remains consistent with the annual trend used for Factor D`.

Indiana is planning to adjust its physician fee schedule to approximately 75% of Medicare, effective January 1, 2015. This is projected to increase reimbursement for affected services by 20% in aggregate. Affected services represent approximately 10% of state plan service expenditures for this population, so in addition to annual trend, we have included a one-time adjustment of 2% to Factor G` for WY 1 of the renewal.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Services	**manage components**
Case Management	**manage components**
Prevocational Services	**manage components**
Respite	**manage components**
Occupational Therapy	**manage components**
Physical Therapy	**manage components**
Psychological Therapy	**manage components**
Speech/Language Therapy	**manage components**
Behavioral Support Services	**manage components**

Waiver Services	
Community Based Habilitation - Group	manage components
Community Based Habilitation - Individual	manage components
Extended Services	manage components
Facility Based Habilitation - Group	manage components
Facility Based Habilitation - Individual	manage components
Facility Based Support Services	manage components
Family and Caregiver Training	manage components
Intensive Behavioral Intervention	manage components
Music Therapy	manage components
Participant Assistance and Care	manage components
Personal Emergency Response System	manage components
Recreational Therapy	manage components
Specialized Medical Equipment and Supplies	manage components
Transportation	manage components
Workplace Assistance	manage components

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. **Estimate of Factor D.**

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Family Supports Waiver

State of Indiana Family and Social Services Administration (FSSA)
Indiana Office of Medicaid Policy and Planning (OMPP)
Division of Disability and Rehabilitative Services (DDRS)

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Appendix J-2-d: Estimate of Factor D - Non-Concurrent Waiver

Waiver Year: Year 1

	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**#Users**	**Avg Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Adult Day Services - 1/4 hour - Level 1	1/4 hour	26	4,241	$ 1.38	$ 152,167.08
Adult Day Services - 1/4 hour - Level 2	1/4 hour	40	3,706	$ 1.80	$ 266,832.00
Adult Day Services - 1/4 hour - Level 3	1/4 hour	24	2,883	$ 2.14	$ 148,070.88
Case Management	month	14,171	11	$ 124.96	$ 19,478,889.76
Prevocational Services: Small	hour	1,933	59	$ 8.24	$ 939,747.28
Prevocational Services: Medium	hour	3,165	754	$ 4.66	$ 11,120,670.60
Prevocational Services: Large	hour	2,276	262	$ 2.87	$ 1,711,415.44
Respite Nursing Care (RN)	1/4 hour	17	880	$ 7.79	$ 116,538.40
Respite Nursing Care (LPN)	1/4 hour	17	551	$ 5.91	$ 55,358.97
Respite Services	hour	4,149	207	$ 23.54	$ 20,217,164.22
Extended Services	hour	1,018	69	$ 35.19	$ 2,471,815.98
Occupational Therapy	1/4 hour	1	1	$ 17.99	$ 17.99
Physical Therapy	1/4 hour	5	35	$ 17.81	$ 3,116.75
Psychological Therapy - Family	1/4 hour	1	1	$ 17.27	$ 17.27
Psychological Therapy - Individual	1/4 hour	33	8	$ 15.45	$ 4,078.80

Psychological Therapy - Group	1/4 hour	34	10	$ 4.81	$ 1,635.40
Speech/Language Therapy	1/4 hour	1	1	$ 18.12	$ 18.12
Behavioral Support Services - Level 1	1/4 hour	2,324	9	$ 18.00	$ 376,488.00
Behavioral Support Services - Level 2	1/4 hour	3,082	218	$ 16.70	$ 11,220,329.20
Community Based Habilitation: Small	hour	2,594	109	$ 8.39	$ 2,372,238.94
Community Based Habilitation: Medium	hour	544	38	$ 4.67	$ 96,538.24
Community Based Habilitation - Individual	hour	3,727	160	$ 22.19	$ 13,232,340.80
Facility Based Habilitation: Small	hour	3,043	226	$ 8.25	$ 5,673,673.50
Facility Based Habilitation: Medium	hour	2,449	381	$ 4.67	$ 4,357,432.23
Facility Based Habilitation: Large	hour	729	27	$ 3.00	$ 59,049.00
Facility Based Habilitation - Individual	hour	1,594	61	$ 21.98	$ 2,137,203.32
Facility Based Support Services	hour	1	1	$ 1.85	$ 1.85
Family and Caregiver Training - Family	unit	15	1	$ 982.25	$ 14,733.75
Family and Caregiver Training - Non-Family	unit	1	1	$ 2,000.00	$ 2,000.00
Intensive Behavioral Intervention - Level 1	hour	1	1	$ 104.60	$ 104.60
Intensive Behavioral Intervention - Level 2	hour	1	1	$ 25.00	$ 25.00
Music Therapy	1/4 hour	1,816	174	$ 10.77	$ 3,403,147.68
Participant Assistance and Care	hour	2,834	197	$ 22.95	$ 12,812,939.10
Personal Emergency Response System - Installation	unit	5	2	$ 52.07	$ 520.70
Personal Emergency Response System - Maintenance	month	107	11	$ 39.70	$ 46,726.90
Recreational Therapy	1/4 hour	607	242	$ 10.73	$ 1,576,172.62
Specialized Medical Equipment and Supplies - Installation	unit	12	1	$ 2,526.61	$ 30,319.32
Specialized Medical Equipment and Supplies - Maintenance	unit	1	1	$ 2,421.43	$ 2,421.43
Transportation	trip	3,571	286	$ 4.97	$ 5,075,890.82
Workplace Assistance	hour	3	95	$ 26.37	$ 7,515.45
GRAND TOTAL:					$ 119,185,367.39
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					14,171
FACTOR D (Divide grand total by number of participants)					$ 8,410.51
AVERAGE LENGTH OF STAY ON WAIVER					318

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Family Supports Waiver

State of Indiana Family and Social Services Administration (FSSA)
Indiana Office of Medicaid Policy and Planning (OMPP)
Division of Disability and Rehabilitative Services (DDRS)

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Appendix J-2-d: Estimate of Factor D - Non-Concurrent Waiver

Waiver Year: Year 2

	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**#Users**	**Avg Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Adult Day Services - 1/4 hour - Level 1	1/4 hour	31	4,334	$ 1.41	$ 189,439.14
Adult Day Services - 1/4 hour - Level 2	1/4 hour	47	3,787	$ 1.84	$ 327,499.76
Adult Day Services - 1/4 hour - Level 3	1/4 hour	29	2,946	$ 2.18	$ 186,246.12
Case Management	month	16,942	11	$ 127.46	$ 23,753,700.52
Prevocational Services: Small	hour	2,311	60	$ 8.40	$ 1,164,744.00
Prevocational Services: Medium	hour	3,784	771	$ 4.75	$ 13,857,954.00
Prevocational Services: Large	hour	2,721	268	$ 2.93	$ 2,136,638.04
Respite Nursing Care (RN)	1/4 hour	21	899	$ 7.95	$ 150,088.05
Respite Nursing Care (LPN)	1/4 hour	21	564	$ 6.03	$ 71,419.32
Respite Services	hour	4,960	211	$ 24.58	$ 25,724,444.80
Extended Services	hour	1,217	70	$ 35.89	$ 3,057,469.10
Occupational Therapy	1/4 hour	2	1	$ 18.35	$ 36.70
Physical Therapy	1/4 hour	6	36	$ 18.17	$ 3,924.72
Psychological Therapy - Family	1/4 hour	2	1	$ 17.62	$ 35.24
Psychological Therapy - Individual	1/4 hour	39	8	$ 15.76	$ 4,917.12
Psychological Therapy - Group	1/4 hour	41	10	$ 4.91	$ 2,013.10
Speech/Language Therapy	1/4 hour	2	1	$ 18.48	$ 36.96

Behavioral Support Services - Level 1	1/4 hour	2,778	9	$ 18.36	$ 459,036.72
Behavioral Support Services - Level 2	1/4 hour	3,685	223	$ 17.03	$ 13,994,487.65
Community Based Habilitation: Small	hour	3,101	111	$ 8.56	$ 2,946,446.16
Community Based Habilitation: Medium	hour	650	39	$ 4.76	$ 120,666.00
Community Based Habilitation - Individual	hour	4,456	164	$ 23.17	$ 16,932,265.28
Facility Based Habilitation: Small	hour	3,638	231	$ 8.42	$ 7,075,982.76
Facility Based Habilitation: Medium	hour	2,928	389	$ 4.76	$ 5,421,601.92
Facility Based Habilitation: Large	hour	872	28	$ 3.06	$ 74,712.96
Facility Based Habilitation - Individual	hour	1,906	63	$ 22.95	$ 2,755,790.10
Facility Based Support Services	hour	2	1	$ 1.89	$ 3.78
Family and Caregiver Training - Family	unit	19	2	$ 1,001.90	$ 38,072.20
Family and Caregiver Training - Non-Family	unit	2	1	$ 2,040.00	$ 4,080.00
Intensive Behavioral Intervention - Level 1	hour	2	1	$ 106.69	$ 213.38
Intensive Behavioral Intervention - Level 2	hour	2	1	$ 25.50	$ 51.00
Music Therapy	1/4 hour	2,172	178	$ 10.99	$ 4,248,909.84
Participant Assistance and Care	hour	3,388	201	$ 23.41	$ 15,941,929.08
Personal Emergency Response System - Installation	unit	6	2	$ 53.11	$ 637.32
Personal Emergency Response System - Maintenance	month	127	11	$ 40.49	$ 56,564.53
Recreational Therapy	1/4 hour	726	247	$ 10.94	$ 1,961,782.68
Specialized Medical Equipment and Supplies - Installation	unit	14	1	$ 2,577.14	$ 36,079.96
Specialized Medical Equipment and Supplies - Maintenance	unit	2	1	$ 2,469.86	$ 4,939.72
Transportation	trip	4,269	292	$ 5.07	$ 6,319,998.36
Workplace Assistance	hour	4	97	$ 26.90	$ 10,437.20
GRAND TOTAL:					$ 149,035,295.29
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					16,942
FACTOR D (Divide grand total by number of participants)					$ 8,797.00
AVERAGE LENGTH OF STAY ON WAIVER					325

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

e. **Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Family Supports Waiver

State of Indiana Family and Social Services Administration (FSSA)
Indiana Office of Medicaid Policy and Planning (OMPP)
Division of Disability and Rehabilitative Services (DDRS)

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Appendix J-2-d: Estimate of Factor D - Non-Concurrent Waiver

Waiver Year: Year 3

	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**#Users**	**Avg Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Adult Day Services - 1/4 hour - Level 1	1/4 hour	36	4,387	$ 1.44	$ 227,422.08
Adult Day Services - 1/4 hour - Level 2	1/4 hour	55	3,834	$ 1.87	$ 394,326.90
Adult Day Services - 1/4 hour - Level 3	1/4 hour	33	2,982	$ 2.23	$ 219,445.38
Case Management	month	19,713	11	$ 130.01	$ 28,191,758.43
Prevocational Services: Small	hour	2,689	61	$ 8.57	$ 1,405,728.53
Prevocational Services: Medium	hour	4,403	780	$ 4.85	$ 16,656,549.00
Prevocational Services: Large	hour	3,166	271	$ 2.99	$ 2,565,378.14
Respite Nursing Care (RN)	1/4 hour	24	910	$ 8.10	$ 176,904.00
Respite Nursing Care (LPN)	1/4 hour	24	571	$ 6.15	$ 84,279.60
Respite Services	hour	5,771	214	$ 25.07	$ 30,961,299.58
Extended Services	hour	1,416	71	$ 36.61	$ 3,680,622.96
Occupational Therapy	1/4 hour	2	1	$ 18.72	$ 37.44
Physical Therapy	1/4 hour	7	37	$ 18.53	$ 4,799.27
Psychological Therapy - Family	1/4 hour	2	1	$ 17.97	$ 35.94
Psychological Therapy - Individual	1/4 hour	45	8	$ 16.07	$ 5,785.20
Psychological Therapy - Group	1/4 hour	48	10	$ 5.00	$ 2,400.00
Speech/Language Therapy	1/4 hour	2	1	$ 18.85	$ 37.70
Behavioral Support Services - Level 1	1/4 hour	3,233	10	$ 18.73	$ 605,540.90
Behavioral Support Services - Level 2	1/4 hour	4,288	226	$ 17.37	$ 16,833,058.56

Community Based Habilitation: Small	hour	3,608	113	$ 8.73	$ 3,559,255.92
Community Based Habilitation: Medium	hour	756	39	$ 4.86	$ 143,292.24
Community Based Habilitation - Individual	hour	5,185	166	$ 23.63	$ 20,338,577.30
Facility Based Habilitation: Small	hour	4,233	234	$ 8.58	$ 8,498,678.76
Facility Based Habilitation: Medium	hour	3,407	394	$ 4.86	$ 6,523,859.88
Facility Based Habilitation: Large	hour	1,015	28	$ 3.12	$ 88,670.40
Facility Based Habilitation - Individual	hour	2,218	63	$ 23.41	$ 3,271,172.94
Facility Based Support Services	hour	2	1	$ 1.92	$ 3.84
Family and Caregiver Training - Family	unit	22	2	$ 1,021.93	$ 44,964.92
Family and Caregiver Training - Non-Family	unit	2	1	$ 2,080.80	$ 4,161.60
Intensive Behavioral Intervention - Level 1	hour	2	1	$ 108.83	$ 217.66
Intensive Behavioral Intervention - Level 2	hour	2	1	$ 26.01	$ 52.02
Music Therapy	1/4 hour	2,527	181	$ 11.21	$ 5,127,308.27
Participant Assistance and Care	hour	3,943	204	$ 23.88	$ 19,208,403.36
Personal Emergency Response System - Installation	unit	7	2	$ 54.17	$ 758.38
Personal Emergency Response System - Maintenance	month	148	11	$ 41.30	$ 67,236.40
Recreational Therapy	1/4 hour	845	250	$ 11.16	$ 2,357,550.00
Specialized Medical Equipment and Supplies - Installation	unit	17	1	$ 2,628.69	$ 44,687.73
Specialized Medical Equipment and Supplies - Maintenance	unit	2	1	$ 2,519.26	$ 5,038.52
Transportation	trip	4,967	295	$ 5.17	$ 7,575,420.05
Workplace Assistance	hour	5	98	$ 27.44	$ 13,445.60
GRAND TOTAL:					$ 178,888,165.40
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					19,713
FACTOR D (Divide grand total by number of participants)					$ 9,074.63
AVERAGE LENGTH OF STAY ON WAIVER					329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

f. **Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Family Supports Waiver

State of Indiana Family and Social Services Administration (FSSA)
Indiana Office of Medicaid Policy and Planning (OMPP)
Division of Disability and Rehabilitative Services (DDRS)

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Appendix J-2-d: Estimate of Factor D - Non-Concurrent Waiver

Waiver Year: Year 4

	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**#Users**	**Avg Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Adult Day Services - 1/4 hour - Level 1	1/4 hour	41	4,414	$ 1.46	$ 264,222.04
Adult Day Services - 1/4 hour - Level 2	1/4 hour	63	3,857	$ 1.91	$ 464,112.81
Adult Day Services - 1/4 hour - Level 3	1/4 hour	38	3,000	$ 2.27	$ 258,780.00
Case Management	month	22,484	11	$ 132.61	$ 32,797,635.64
Prevocational Services: Small	hour	3,067	61	$ 8.74	$ 1,635,140.38
Prevocational Services: Medium	hour	5,021	785	$ 4.95	$ 19,510,350.75
Prevocational Services: Large	hour	3,611	273	$ 3.05	$ 3,006,699.15
Respite Nursing Care (RN)	1/4 hour	27	916	$ 8.27	$ 204,533.64
Respite Nursing Care (LPN)	1/4 hour	27	574	$ 6.27	$ 97,172.46
Respite Services	hour	6,582	215	$ 25.58	$ 36,199,025.40
Extended Services	hour	1,616	71	$ 37.34	$ 4,284,242.24
Occupational Therapy	1/4 hour	2	1	$ 19.09	$ 38.18
Physical Therapy	1/4 hour	8	37	$ 18.90	$ 5,594.40
Psychological Therapy - Family	1/4 hour	2	1	$ 18.33	$ 36.66
Psychological Therapy - Individual	1/4 hour	52	8	$ 16.40	$ 6,822.40
Psychological Therapy - Group	1/4 hour	55	10	$ 5.10	$ 2,805.00
Speech/Language Therapy	1/4 hour	2	1	$ 19.23	$ 38.46
Behavioral Support Services - Level 1	1/4 hour	3,687	10	$ 19.10	$ 704,217.00
Behavioral Support Services - Level 2	1/4 hour	4,890	227	$ 17.72	$ 19,669,731.60
Community Based Habilitation: Small	hour	4,115	113	$ 8.90	$ 4,138,455.50
Community Based Habilitation: Medium	hour	862	39	$ 4.96	$ 166,745.28

Community Based Habilitation - Individual	hour	5,914	167	$ 24.10	$ 23,802,075.80
Facility Based Habilitation: Small	hour	4,828	236	$ 8.75	$ 9,969,820.00
Facility Based Habilitation: Medium	hour	3,886	396	$ 4.96	$ 7,632,725.76
Facility Based Habilitation: Large	hour	1,157	29	$ 3.18	$ 106,698.54
Facility Based Habilitation - Individual	hour	2,530	64	$ 23.88	$ 3,866,649.60
Facility Based Support Services	hour	2	1	$ 1.96	$ 3.92
Family and Caregiver Training - Family	unit	25	2	$ 1,042.37	$ 52,118.50
Family and Caregiver Training - Non-Family	unit	2	1	$ 2,122.42	$ 4,244.84
Intensive Behavioral Intervention - Level 1	hour	2	1	$ 111.00	$ 222.00
Intensive Behavioral Intervention - Level 2	hour	2	1	$ 26.53	$ 53.06
Music Therapy	1/4 hour	2,882	182	$ 11.43	$ 5,995,309.32
Participant Assistance and Care	hour	4,497	205	$ 24.35	$ 22,447,899.75
Personal Emergency Response System - Installation	unit	8	2	$ 55.26	$ 884.16
Personal Emergency Response System - Maintenance	month	169	11	$ 42.13	$ 78,319.67
Recreational Therapy	1/4 hour	963	252	$ 11.39	$ 2,764,079.64
Specialized Medical Equipment and Supplies - Installation	unit	19	1	$ 2,681.26	$ 50,943.94
Specialized Medical Equipment and Supplies - Maintenance	unit	2	1	$ 2,569.65	$ 5,139.30
Transportation	trip	5,665	297	$ 5.27	$ 8,866,801.35
Workplace Assistance	hour	5	99	$ 27.98	$ 13,850.10
GRAND TOTAL:					$ 209,074,238.24
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					22,484
FACTOR D (Divide grand total by number of participants)					$ 9,298.80
AVERAGE LENGTH OF STAY ON WAIVER					331

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. **Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Family Supports Waiver

State of Indiana Family and Social Services Administration (FSSA)
Indiana Office of Medicaid Policy and Planning (OMPP)
Division of Disability and Rehabilitative Services (DDRS)

Third Renewal April 1, 2015 - March 31, 2020

Appendix J-2-d: Estimate of Factor D - Non-Concurrent Waiver

Waiver Year: Year 5

	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Waiver Service	**Unit**	**#Users**	**Avg Units Per User**	**Avg. Cost/Unit**	**Total Cost**
Adult Day Services - 1/4 hour - Level 1	1/4 hour	46	4,454	$ 1.49	$ 305,277.16
Adult Day Services - 1/4 hour - Level 2	1/4 hour	71	3,892	$ 1.95	$ 538,847.40
Adult Day Services - 1/4 hour - Level 3	1/4 hour	43	3,028	$ 2.32	$ 302,073.28
Case Management	month	25,258	11	$ 135.26	$ 37,580,367.88
Prevocational Services: Small	hour	3,446	62	$ 8.92	$ 1,905,775.84
Prevocational Services: Medium	hour	5,641	792	$ 5.04	$ 22,517,066.88
Prevocational Services: Large	hour	4,056	276	$ 3.11	$ 3,481,508.16
Respite Nursing Care (RN)	1/4 hour	31	924	$ 8.43	$ 241,468.92
Respite Nursing Care (LPN)	1/4 hour	31	579	$ 6.40	$ 114,873.60
Respite Services	hour	7,395	217	$ 26.09	$ 41,867,014.35
Extended Services	hour	1,815	72	$ 38.09	$ 4,977,601.20
Occupational Therapy	1/4 hour	2	1	$ 19.47	$ 38.94
Physical Therapy	1/4 hour	9	37	$ 19.28	$ 6,420.24
Psychological Therapy - Family	1/4 hour	2	1	$ 18.69	$ 37.38

Psychological Therapy - Individual	1/4 hour	58	8	$ 16.72	$ 7,758.08
Psychological Therapy - Group	1/4 hour	61	10	$ 5.21	$ 3,178.10
Speech/Language Therapy	1/4 hour	2	1	$ 19.61	$ 39.22
Behavioral Support Services - Level 1	1/4 hour	4,142	10	$ 19.48	$ 806,861.60
Behavioral Support Services - Level 2	1/4 hour	5,494	229	$ 18.08	$ 22,746,918.08
Community Based Habilitation: Small	hour	4,623	114	$ 9.08	$ 4,785,359.76
Community Based Habilitation: Medium	hour	969	40	$ 5.05	$ 195,738.00
Community Based Habilitation - Individual	hour	6,643	168	$ 24.58	$ 27,431,869.92
Facility Based Habilitation: Small	hour	5,423	238	$ 8.93	$ 11,525,718.82
Facility Based Habilitation: Medium	hour	4,366	400	$ 5.05	$ 8,819,320.00
Facility Based Habilitation: Large	hour	1,300	29	$ 3.25	$ 122,525.00
Facility Based Habilitation - Individual	hour	2,842	64	$ 24.36	$ 4,430,791.68
Facility Based Support Services	hour	2	1	$ 2.00	$ 4.00
Family and Caregiver Training - Family	unit	28	2	$ 1,063.22	$ 59,540.32
Family and Caregiver Training - Non-Family	unit	2	1	$ 2,164.86	$ 4,329.72
Intensive Behavioral Intervention - Level 1	hour	2	1	$ 113.22	$ 226.44
Intensive Behavioral Intervention - Level 2	hour	2	1	$ 27.06	$ 54.12
Music Therapy	1/4 hour	3,237	183	$ 11.66	$ 6,907,045.86
Participant Assistance and Care	hour	5,052	207	$ 24.84	$ 25,976,777.76
Personal Emergency Response System - Installation	unit	9	2	$ 56.36	$ 1,014.48
Personal Emergency Response System - Maintenance	month	190	11	$ 42.97	$ 89,807.30
Recreational Therapy	1/4 hour	1,082	254	$ 11.61	$ 3,190,753.08
Specialized Medical Equipment and Supplies - Installation	unit	21	1	$ 2,734.88	$ 57,432.48
Specialized Medical Equipment and Supplies - Maintenance	unit	2	1	$ 2,621.04	$ 5,242.08
Transportation	trip	6,364	300	$ 5.38	$ 10,271,496.00
Workplace Assistance	hour	6	100	$ 28.54	$ 17,124.00
GRAND TOTAL:					$ 241,295,297.13
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					25,258
FACTOR D (Divide grand total by number of participants)					$ 9,553.22
AVERAGE LENGTH OF STAY ON WAIVER					334